

Sterilization Consent Form Detailed Instructions Guide

It is the responsibility of the **performing surgeon to submit a legible completed** copy of the Sterilization Consent Form (Form 193) **after** the surgery to Medicaid's fiscal agent, DXC. Consent forms should not be submitted to DXC prior to the surgery date. Receipt of multiple consent forms slow down the consent form review process and payment of claims. For timely processing, providers must complete all required fields and the performing surgeon must submit a copy of the recipient's signed Sterilization Consent Form to DXC using the Providers Web Portal upload process or via the fax number listed below:

DXC
ATTN: Medical Policy Unit/Consent Forms
Fax Number: (334) 215-7416

If submitting this form via fax, a barcode fax coversheet is required with each submission and should be included as page one of the fax transmission for the corresponding Record ID.

Effective November 28, 2016, DXC will not accept Consent Forms and supporting documentation in paper format. Consent Forms and supporting documents submitted to DXC in paper format on/after November 28, 2016 will be returned to the provider.

Only an electronic fillable version of the Sterilization Consent Form can be faxed to DXC. **The electronic fillable version of the Sterilization Consent Form** is located on the Alabama Medicaid's Agency's website at the following link: http://www.medicaid.alabama.gov/documents/9.0_Resources/9.4_Forms_Library/9.4.3_Consent_Forms/9.4.3_Form_193_Consent_Sterilization_Fillable_9-26-16.pdf. The electronic fillable version must be printed to complete the signatures and dates. **All SIGNATURES AND DATES MUST BE COMPLETED IN BLACK INK TO ENSURE FAXED COPIES ARE LEGIBLE.**

Note: DXC will **not** accept any Sterilization Consent Forms by **email**.

Reference Section C.3.3 for updates regarding the digital submission of the Sterilization Consent Form and supporting documentation effective October 26, 2016.

All blanks on the Sterilization Consent Form must be appropriately completed. DXC will NOT pay any claims to ANY provider until a correctly completed Alabama Medicaid Agency Sterilization Consent Form (Form 193) is on file at DXC.

DXC will return forms to the provider upon identification of missing or invalid information in correctable fields. **Consent forms submitted to DXC with missing and/or invalid information in *NON-CORRECTABLE FIELDS [Fields 7, 8, (12 & 13, if provided), 16 and 17] of the consent form will be denied by DXC and not returned to the provider, therefore all claims associated with the sterilization WILL NOT BE PAID.**

Before sending the consent form to DXC, it is imperative that the **date of surgery** be clarified by reviewing the operative note to remedy claim denials due to incorrect date of surgery.

NOTE:

A ***NON-CORRECTABLE FIELD** is a field that cannot be changed, edited or revised once the Sterilization Consent Form has been submitted to DXC.

Missing and/or invalid information in a ***NON-CORRECTABLE FIELD** will cause the consent form to be denied, which **WILL** result in **NONE-PAYMENT** of **ALL** provider claims.

NOTE:

All **signature** and **date** lines on the Sterilization Consent Form noted with an “X” must be completed after the form is printed.

CONSENT TO STERILIZATION INSTRUCTIONS

FIELD	DESCRIPTION	INSTRUCTIONS
1	Name of physician or clinic	Enter the typed or printed name of the physician or clinic that will provide information about the sterilization.
2	Specify type of operation	Enter of the type of operation that will be performed.
3	Recipient’s date of birth	Enter the recipient’s date of birth in the following format: month/day/year. Note: The recipient must be at least 21 years of age at the time consent is obtained. If the recipient was not 21 years of age when the Sterilization Consent Form was signed, the consent form will be denied.
4	Recipient’s name	Enter the typed or printed first and last name of the recipient.
5	Name of physician or clinic	Enter the typed or printed name of the physician or clinic that will perform the operation.
6	Specify type of operation	Enter of the type of operation that will be performed.

*7	Recipient's signature	<p>The recipient must sign his/her first and last name.</p> <p><i>(If the patient is unable to sign their name, the physician's office is responsible for documenting the reason why, either on the consent form or on attached documentation. If the individual consenting to sterilization is unable to write at all, due to a physical disability, they should have someone sign for them, in the presence of a witness. The witness must be someone other than those individuals required by regulations to be parties to the consent process. Therefore, the witness cannot be the person obtaining consent, the interpreter, or the physician. This same process should be used when the individual cannot write his or her name and signs with an "X".)</i></p> <p>*Note: The recipient's signature on the Sterilization Consent Form is considered a <u>NON-CORRECTABLE FIELD</u> and cannot be changed, edited or revised once submitted to DXC.</p>
*8	Date recipient signed	<p>The recipient must provide the date the Sterilization Consent Form was signed.</p> <ul style="list-style-type: none"> • The date of the recipient's signature must be in the following format: month/day/year. • The required 30-day waiting period is calculated from this date. • The recipient's signature date must reflect at least 30 days, but not more than 180 days have passed prior to the procedure being done, except in the case of premature delivery or emergency abdominal surgery. • This date must be added at the time the recipient signs the form. • The date cannot be altered or added at a later date. <p>*Note: The date the recipient signed the Sterilization Consent Form is considered a <u>NON-CORRECTABLE FIELD</u> and cannot be changed, edited or revised once submitted to DXC.</p>
9	Recipient's name	Enter the typed or printed first and last name of the recipient.

10	Recipient's Medicaid Number	Enter the recipient's 13-digit Alabama Medicaid number.
INTERPRETER'S STATEMENT		
11	Language	Enter the language used by the interpreter to communicate the information to the recipient. Note: If an interpreter is used, this section must be completed in full. If an interpreter is not used, N/A can be written into this section. If this section is blank, the Sterilization Consent Form will be returned to the provider for correction.
*12	Interpreter's signature	The interpreter must sign the Sterilization Consent Form at the same time or after the recipient signs. *Note: The signature of the interpreter of the Sterilization Consent Form is considered a <u>NON-CORRECTABLE FIELD</u> and cannot be changed, edited or revised once submitted to DXC.
*13	Date of interpreter's signature	The interpreter must date the form in the following format: month/day/year . *Note: The date of the signing of the Sterilization Consent Form by the interpreter is considered a <u>NON-CORRECTABLE FIELD</u> and cannot be changed, edited or revised once submitted to DXC.
STATEMENT OF PERSON OBTAINING CONSENT		
14	Recipient's name	Enter the typed or printed first and last name of the recipient.
15	Specify type of operation	Enter the type of operation that will be performed.

*16	Signature of person obtaining consent	The person obtaining consent must sign the Sterilization Consent Form at the same time or after the recipient, but PRIOR to the date of sterilization. *Note: The signature of the person obtaining consent is considered a <u>NON-CORRECTABLE FIELD</u> and cannot be changed, edited or revised once submitted to DXC.
*17	Date of signature of person obtaining consent	The person obtaining consent must date the form in the following format: month/day/year. The person obtaining consent signature date will reflect at least 30 days , but not more than 180 days have passed prior to the procedure being done. *Note: The date of the person obtaining consent is considered a <u>NON-CORRECTABLE FIELD</u> and cannot be changed, edited or revised once submitted to DXC.
18	Name of person obtaining consent	Enter the typed or printed first and last name of the person obtaining consent.
19	Facility name	Enter the name of the facility where the recipient received counseling.
20	Facility address	Enter the address of the facility where the recipient received the sterilization information.
PHYSICIAN'S STATEMENT		
21	Recipient's name	Enter the typed or printed first and last name of the recipient.
22	Date of sterilization	Enter the date the sterilization was performed in the following format: month/day/year . NOTE: It is imperative that the date of surgery be clarified by reviewing the operative note to remedy claims denials due to incorrect of surgery.
23	Specify type of operation	Enter the type of operation that will be performed.

24	Instructions for use of alternative final paragraphs	<p>Cross out the paragraph, which is not used.</p> <ul style="list-style-type: none"> • At least thirty days have passed between the date of the recipient’s signature on the Sterilization Consent Form and the date the sterilization was performed. • This sterilization was performed less than 30 days but more than 72 hours after the date of the recipient’s signature on this Sterilization Consent Form because of the following circumstances (check applicable box and fill in information requested): <ul style="list-style-type: none"> <input type="checkbox"/> Premature delivery Recipient’s expected date of delivery: <input type="checkbox"/> Emergency abdominal surgery (describe circumstances in an attachment) <p>Enter the recipient’s expected date of delivery in the following format: month/day/year.</p>
25	Physician’s signature	<p>The physician’s signature can only be affixed after the sterilization procedure is performed. This field must contain the signature of the physician who performed the procedure. Signature stamps are not permissible in this field.</p> <p>Note: The physician may sign on the same day of the procedure or any time after the sterilization procedure is performed.</p>
26	Date of physician’s signature	<p>The date of the physician’s signature must be in the following format: month/day/year and must be on or after the date of the surgery.</p>
27	Name of the physician	<p>Enter the type or printed first and last name of the physician.</p>
28	Medicaid Provider Identifier Number (NPI)	<p>Enter the physician’s National Provider Identifier (NPI).</p>